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SIGNATURE ON FILE

I request that payment of authorized insurance benefits be made either to me or on my behalf to Dr. Anthony Farole for any services furnished me by Dr. Farole.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services.

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Signature of the Insured ***Date***

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Signature of Patient (If different from insurer.) *Date*